CONTRA COSTA COUNTY

2017 Employee Benefits

Information and Open Enrollment Guide

Benefit Elections for Plan Year January 1, 2017 through December 31, 2017

Open Enrollment Period is October 10, 2016 through October 28, 2016

Contra Costa County Department of Human Resources
Employee Benefits Services Unit
651 Pine Street, Fifth Floor
Martinez, CA 94553-1292
(925) 335-1746

Dear Employees:

We are pleased to provide you with the 2017 Employee Benefits Information for eligible employees of Contra Costa County. Open Enrollment will begin at 8:00 AM on Monday, October 10, 2016 and ends at 5:00 PM on Friday, October 28, 2016. All original enrollment forms and required dependent documentation must be received by the Employee Benefits Services Unit of the Human Resources Department during the Open Enrollment Period.

New for Plan Year 2017:

The County was able to negotiate a Special Enrollment Period for Supplemental Term Life coverage. All eligible employees who are not currently enrolled in Supplemental Term Life Insurance will have this Special Enrollment Period to apply for coverage. This Special Enrollment Period allows employees to get up to $100,000 in coverage with no evidence of insurability, meaning that you will be able to enroll for up to $100,000 with no medical questions asked. If your current Supplemental Term Life Insurance coverage is less than $100,000 you may increase your election up to the $100,000 level with no Evidence of Insurability. http://www.co.contra-costa.ca.us/1355/Life-Insurance-Programs.

Remember participants in the Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP) must re-enroll each year. Enrollment forms may be found on-line at http://www.co.contra-costa.ca.us/1354/Health-Care-Spending-Account or http://www.co.contra-costa.ca.us/1353/Dependent-Care-Assistance-Program.

The elections you make during this Open Enrollment period are effective for the Plan Year of January 1, 2017 through December 31, 2017. If you are not making any changes to your current plans or those who are covered by your current medical and dental plans, you do not need to complete any forms. If you are changing carriers, adding or deleting dependents, or participating in the HCSA or DCAP, you do need to complete the appropriate forms and provide the required documentation.

Please make sure you review all the information carefully.

- Refer to your 2016 Employee Benefits Statement that you received in the mail to confirm in which plans you currently participate and which family members are covered by your plans. And, also review the beneficiary area to make sure it is correct. The beneficiaries shown on your 2016 Employee Benefit Statement are your designated beneficiaries for Life and AD&D Insurance only.
- Refer to the comparison charts in this guide to understand varying plan provisions.
- Review the online SBCs to understand the differences in the health plans.

Please be sure to complete and submit all enrollment forms and required documentation during the Open Enrollment period of October 10, 2016 through October 28, 2016.

As always, should you have any questions, please contact the Human Resources Department, Employee Benefits Services Unit at 925-335-1746 or send by email at benefits@hrd.cccounty.us or by visiting our office at 651 Pine Street, Fifth Floor, Martinez, CA. Our office is Open Monday through Friday from 8:00AM to 5:00PM.

Best regards,

Your Human Resources Department
Employee Benefits Services Unit

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Open Enrollment Period

The open enrollment period begins at 8:00 AM on Monday October 10, 2016 and ends at 5:00 PM on Friday October 28, 2016

During this period, eligible employees may:

- Enroll in a medical and dental plan, if you are eligible and you currently do not have medical or dental benefits
- Change your medical or dental plan
- Add or drop eligible dependent's medical or dental coverage
- Enroll in the 2017 Health Care Spending Account Plan
- Enroll in the 2017 Dependent Care Assistance Program

Additionally, it is a good time to:

- Review or amend your life insurance beneficiary
- Add or increase supplemental life insurance, if eligible and subject to completion, submission and approval of Evidence of Insurability
- Review your deferred compensation plan deferrals, investment options and beneficiaries

When Enrolling In Plans, Remember:

- Premiums are deducted from your paycheck on the 10th of each month. If you do not have enough money in your paycheck for the full deduction, a partial deduction will not be taken. It is your responsibility to pay the full monthly premium due in the form of a check payable to Contra Costa County by the 10th of the month, the same as if the amount was deducted from your paycheck.
- Medical, dental, health care spending account and dependent care assistance programs elected during open enrollment will be effective January 1, 2017 through December 31, 2017. If you do not make any changes during the open enrollment period, your current medical and dental plan elections as well as your current premium conversion plan election will remain in effect for calendar year 2017.
- The Health Care Spending Account and Dependent Care Assistance Program require re-enrollment every Plan Year.
- Employees who add their spouse, domestic partner and /or dependent child(ren) on their medical or dental plan must submit documentation verifying dependent eligibility.

Eligibility

Management, Exempt and Unrepresented Employees -

Employees regularly scheduled to work at least 20 hours per week are eligible to participate in the Medical, Dental and Life Insurance programs as well as Health Care Spending Account, Dependent Care Assistance Program, premium conversion plan and the deferred compensation plan. Employees regularly scheduled to work less than 20 hours per week, intermittently or on a provisional basis may be eligible to participate in the medical, dental, life and premium conversion plans; however, these employees are required to pay the total monthly premium without a County subsidy.

Represented Employees -

Eligibility to participate in the Employee Benefit Programs is defined in each Memorandum of Understanding (MOU). Generally speaking, employees regularly scheduled to work at least 20 hours per week are eligible to participate in the medical, dental and life insurance programs as well as health care spending account, dependent care assistance program, premium conversion plan and the deferred compensation plan. Employees regularly scheduled to work less than 20 hours per week, intermittently or on a provisional basis may be eligible to participate in the medical, dental, life and premium conversion plans; however, these employees are required to pay the total monthly premium without a County subsidy. Represented employees should review their specific MOU for further clarification of eligibility, as the hour requirement may vary based on the MOU.

Dependent Eligibility – Medical Insurance Only

The following dependents of an enrolled employee are eligible for health insurance:

- Legal Spouse
- Qualified domestic partner (requires the completing and submitting of certification forms)
- Child to age 26
- Disabled child beyond age 26 who is unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19. The disabled adult dependent must meet the disabled dependent requirements as defined by the health insurance carrier.

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Act of 2010 requires that the County include as eligible dependents adult children until they reach age 26. The Act does not require the County to extend coverage to an employee's grandchildren or to the spouse of the employee's child.

Dependent Eligibility – DeltaCare USA (HMO) Only

The following dependents of an enrolled employee are eligible for DeltaCare USA insurance as of January 1, 2017:

- Legal Spouse
- Qualified domestic partner (requires the completing and submitting of certification forms)
- Child to age 26
- Disabled child beyond age 26 who is unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19. The disabled adult dependent must meet the disabled dependent requirements as defined by the health insurance carrier.

Dependent Eligibility – Delta Dental Insurance Only (PPO) – Voya Supplemental Life

The following dependents of an enrolled employee are eligible for dental and supplemental life coverage:

- Legal Spouse
- Qualified domestic partner (qualified domestic partner enrollment requires the completing and submitting certification forms that are available in the Employee Benefits Services Unit or online)
- Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are
  - ✓ Under age 19;
  - ✓ Age 19 to age 24, who are full-time students, dependent upon you for at least 50% of their support, unmarried and living with you (except when away at school).
  - ✓ Disabled child who is over age 19, unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19 and is your dependent as defined by the Internal Revenue Service

Dependent Eligibility Verification Process

All employees adding dependents must submit documentation verifying eligibility of their covered dependents. Included on the Open Enrollment Change Form (this form was sent to you with your annual benefits statement) is a listing of required documents.

The following chart is an easy guide for which form and documents must be submitted. The chart does not include all possibilities and should be used in conjunction with the Dependent Eligibility Documentation listing on the Open Enrollment Change Form.

For further clarification, please contact the Employee Benefits Services Unit at (925) 335-1746.

Health Insurance and DeltaCare USA	None	Certified Marriage Certificate	Certified Birth Certificate for each child**	Certified State of California DP Registration	Contra Costa County Domestic Partner Registration*
Employee only	●				
Employee & Spouse		●			
Employee & Children under age 26			●		
Employee , Spouse & Children under age 26		●	●		
Employee & Domestic Partner				●	●
Employee/Domestic Partner & Children under age 26			●	●	●

Delta Dental Insurance Only	None	Certified Marriage Certificate	Certified Birth Certificate for each child**	Dependent Verification	Certified State of California DP Registration	Contra Costa County Domestic Partner*
Employee only	●					
Employee & Spouse		●				
Employee & Children under 19 yrs of age			●			
Employee & Children over 19 years of age			●	●		
Employee, Spouse & Children under 19 years of age		●	●			
Employee, Spouse & Children over 19 years of age		●	●	●		
Employee & Domestic Partner only					●	●
Employee, Domestic Partner & Children under 19 years of age			●		●	●
Employee, Domestic Partner & Children over 19 years of age			●	●	●	●

* Must provide Domestic Partner Picture ID, last 6 months of utility bills, bank statements and other such documentation showing a common address.

**Birth Certificates must include the employee's name or the spouse's name or the domestic partner's name. If you do not have a birth certificate with at least one of the aforementioned names included, you must provide a court document that shows you have/had medical care responsibility for the child prior to the child attaining age 19.

For other dependent verification requirements, please refer to the "Dependent Eligibility Documentation" chart on the Open Enrollment change form.

Section 125 Compliance

In compliance with Section 125 of the Internal Revenue Code (IRC), medical, dental or spending account benefit elections may be changed during the plan year only if you have a qualified life status change event, such as:

- A change in your legal marital status, including marriage, divorce, death of your spouse or domestic partner, legal separation or annulment;
- A change in the number of your tax dependents through birth, adoption, placement for adoption, or death;
- Your dependent's ability to satisfy dependent eligibility requirements;
- Termination or commencement of employment of a spouse, domestic partner or eligible dependent;
- A change in work schedule, such as a reduction or increase in hours by your spouse, domestic partner or eligible dependent.
- The taking of an unpaid leave of absence by either you or your spouse;
- A significant change in your or your spouse's coverage that is attributable to the spouse's employment.
- A change in residence or work site by you, your spouse, domestic partner or dependents that causes you to lose access to providers in your HMO plan's network.
- A change in your dependent care provider that increases the cost of dependent care.
- A change as the result of the enrollment or disenrollment of an employee, spouse or dependent for either Part A or Part B of Title XVIII of the Social Security Act (Medicare) or under Title XIX of the Social Security Act (Medicaid).

Both the revoking of a benefit and the new benefit election must due to and consistent with the qualified life status change event. A benefit election change is considered to be consistent with a qualified life status change event only if the election is necessary or appropriate as a result of the change. Family status change forms must be completed and approved within 60 days of the qualifying event date. The change will become effective the first of the month coincident with or next following the date the completed and approved change form is received by the Employee Benefits Services Unit. If you do not complete, submit and receive approval within 60 days of the qualifying event date, you will not be able to add a dependent or make any other changes until the next open enrollment period, with benefits effective on the January 1 following that open enrollment period. Contact the Employee Benefits Services Unit as soon as you experience any of the family status changes listed above.

Open Enrollment. An employee may revoke his/her elections and make new elections with respect to the remainder of the Plan Year if the employee's spouse, domestic partner or dependent child has an open enrollment for a plan with a period of coverage that has an effective date other than January 1 through December 31. No change to the employee's health care spending account election is permitted as a result of this change. An employee must elect such change within ten (10) business days of the effective date of the employee's spouse, domestic partner or dependent child's period of coverage will begin. For example, if your spouse's open enrollment is in June and the Plan Year is July 1 through June 30, you must notify the Employee Benefits Services Unit of this change on or before July 10.

Premium Conversion Plan (PCP)

The PCP allows eligible employees to authorize pre-tax salary reductions to pay monthly medical and dental plan premiums. This benefit does not defer taxes to a later date, it exempts your medical and dental plan contributions from taxes altogether. You may participate in the PCP if you enroll in either the medical or dental plan. Once you enroll, you will continue to participate in this plan until the next open enrollment period when you may choose to revoke your election. If you elect to continue participating in the Premium Conversion Plan, no action is necessary during the open enrollment period.

Healthcare Options

Summary of Benefits and Coverage (SBC)

In accordance with the 2010 Patient Protection and Affordable Care Act, health insurance companies and group health plans are required to provide you with an annual summary about a health plan's benefits and coverage. All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details called "coverage examples" which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

The The SBCs for Contra Costa County Medical Plans are available on the Employee Benefits Website. You should review the SBC documents before electing your medical coverage for Plan Year 2017.

If you do not have access to read or print the SBCs directly from our website, please call the Employee Benefits Office (925-335-1746) and request that a hard copy of the information be sent to you. Or, you may email your request to benefits@hrd.cccounty.us and your reply email will include the SBC requested.

Healthcare Plans

You may choose from a variety of healthcare plans and coverage levels based on your individual needs. A comparison of the healthcare plans is included in the Guide. The healthcare plan in which to enroll is a personal choice. Evaluating the plan alternatives is never easy. The following questions are samples of questions you could consider in determining in which healthcare plan you should elect to participate:

- Which healthcare plan network includes the physician(s) that provide medical services to you and your family members?
- Which healthcare plan network includes the hospital and urgent care centers where your physician(s) have privileges?
- Is the cost or premium deduction amount affordable?
- How often do you expect to use services that include a co-payment? How much do you anticipate paying in co-payments for the calendar year?
- Are ancillary services such as on-line information, preventive care programs, on-line provider ratings or comparisons, and on-line provider searches, etc. important to you?
- Do you and all eligible family members reside within the network service area?
- Do you or your family members always use physicians that are not in any of the healthcare provider networks?

Differences Between The Healthcare Plans

- Health Maintenance Organization (HMO) plans (Contra Costa Health Plans, Kaiser Permanente, and Health Net) offer members a range of health benefits, including preventive care. The HMO will give you a list of doctors from which you select a primary care provider (PCP). Your PCP coordinates your care including referrals to specialists.
- High Deductible Health Plan (HDHP) is a Kaiser Permanente HMO that combines lower premiums with a higher deductible. The Individual or Family deductible must be met before co-insurance and co-pays apply. All Preventive Services (Annual Wellness Physical, Well Child Visits, Immunizations, Preventive Screenings like Mammograms and Colonoscopies) are covered at 100% and are not subject to the deductible.
- Preferred Provider Organization (PPO) plans (Health Net) allow you to select a primary care provider and specialists without referral. You must use doctors in the PPO network or pay higher co-insurance (percentage of charges). In a PPO health plan, you must meet an annual deductible before some benefits apply. You are responsible for a certain co-insurance amount, and the health plan pays the balance up to the allowable amount. When you use a non-participating provider you are responsible for any charges above the amount allowed.

Prescription Drug/Pharmacy Benefit Information

CCHP: Contra Costa Health Plan's Preferred Drug List (PDL) includes a list of drugs that have been approved by the Pharmacy and Therapeutics Committee for members. The PDL is available on line at www.contracostahealthplan.org. Outpatient drugs will be covered that meet patient needs when prescribed by a physician and obtained from a participating pharmacy. If a provider feels that a medication not on the PDL is clinically indicated for a specific patient, he or she always has recourse to the Prior Authorization process. CCHP also has mail order pharmacy service through Walgreens. This service can be accessed at www.walgreensmail.com.

Kaiser Permanente: Kaiser Permanente's formulary uses generic drugs when they are available to meet the patient needs. In addition, Kaiser Permanente will cover brand name drugs and non formulary drugs when medically necessary. Kaiser Permanente's prescription drug formulary is available on line at www.kp.org under the section entitled Health and Wellness tab, and then Drugs and Natural Medicines. Kaiser also has mail order pharmacy service.

Health Net: By logging on to HealthNet.com, selections, I'm a member, California, my pharmacy benefits, Individual, family and group plans, and find a pharmacy, participants may view or print the brochure Pharmacy Benefits Members Guide: Making the Most of Your Pharmacy Benefits. This guide provides information on the formulary, the mail order drug program, pharmacy network, prior authorization, generic drugs, and most importantly, how to navigate the My Pharmacy Benefits section of HealthNet.com. Healthnet also has mail order pharmacy service.

Dental Options

You may elect to participate in one of the two dental plan options and elect the coverage levels based on your individual and family needs.

Selecting a dental plan is a personal choice. The following questions are samples of questions you could consider in determining which dental care plan you should elect:

- Which dental plan network includes the dentist(s) that provide services to you and your family members?
- Is the cost or premium deduction amount affordable?
- How often do you expect to use services that include a co-payment or co-insurance amount that is your responsibility? How much do you anticipate paying in co-payments or co-insurance for the calendar year?
- Do you and all eligible family members reside within the network service area?
- Do you or your family members frequently use dentists that are not in any of the provider networks?

Differences Between Dental Plans

- The Delta Dental Plan (PPO) offers the freedom to choose any licensed dentist; however, maximum out-of-pocket savings is available by choosing a Delta Dentist. Approximately 92% of California dentists are also Delta dentists whose fees are pre-negotiated to keep down costs.
- The DeltaCare USA (HMO) Plan includes a more select number of private and group dental offices. There are minimal out of pocket costs when using DeltaCare HMO. There is an orthodontic benefit included in the Plan. This plan is limited to CA residents.
- A comparison of the dental plans is included in the Guide.

Health Care Spending Account (HCSA)

The HCSA provides an opportunity for employees to authorize a salary reduction on a pre-tax basis to pay for eligible medical, dental and vision expenses that are not covered by the insurance plans. For Plan Year 2017, the maximum HCSA salary reduction amount is $2,550 per year. Again, this amount is not subject to Federal or State Withholding or FICA taxes. Eligible dependents are the same as for medical and dental, except, eligible dependents do not include domestic partners or dependents of domestic partners.

You must enroll in the Health Care Spending Account each Plan Year.

In order to enroll in the HCSA during this Open Enrollment Period, your employment date must be prior to July 1, 2016. If you were hired on or after July 1, 2016, you will be given the opportunity to enroll in the Plan upon meeting eligibility requirements which include six months continuous permanent employment.

To be reimbursed through the HCSA, expenses must be for health care, dental care or vision care received primarily for the prevention or treatment of a physical or mental condition or illness. Out-of-pocket expenses are generally eligible if they are not reimbursed by insurance. Regardless of whether the expenses are incurred by you or your eligible dependents, they must be incurred during the Plan Year or during the period of coverage if you enroll after the Plan Year begins. An expense is incurred when you or one of your dependents receives the services, not when you are billed, charged for, or pay for the services.

To be eligible for reimbursement, a health care expense must be:

- For you, your spouse or qualifying dependent child(ren) as defined by the Internal Revenue Code
- Permitted under the Internal Revenue Code
- Medically necessary; and
- Not reimbursed by your health/dental/vision insurance or any other benefit plan, nor will you seek reimbursement from such plans.

An extensive list of expenses that can be deducted on Schedule A of Form 1040 appears in IRS Publication 502 (Medical and Dental Expenses), although Publication 502 should not be solely relied upon to determine your eligible expenses under the HCSA. For example, expenses such as insurance premiums are deductible on Schedule A, but are not eligible for reimbursement through the HCSA. In addition, the IRS allows you to deduct an expense if it is paid during the tax year, while the HCSA claims are reimbursed only if an expense is incurred during the Plan Year. Expenses reimbursed through your HCSA may not also be deducted on Schedule A.

Keep in mind:

- Some health care treatments or services, including those deemed cosmetic in nature, require proof of medical necessity from your health care provider with your initial reimbursement request and for each subsequent Plan Year that you participate.
- Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement. Prescription drugs that are solely for cosmetic purposes are not eligible for reimbursement.
- The effective date that expenses are incurred for eyeglasses, prosthetic devices and such is the day the item is available to be picked up, not the date ordered.
- Unused funds designated for the HCSA cannot be refunded to you. Please verify with your health care provider (prior to enrolling for the upcoming Plan Year) that you are a suitable candidate for any surgical procedure (i.e. laser eye surgery) before committing the money to your HCSA.
- Expenses incurred for weight loss programs may only be reimbursable if a physician prescribes the treatment as medically necessary to prevent, treat or alleviate a specific diagnosed medical illness such as hypertension, diabetes or obesity.

To enroll in the HCSA, please complete the Health Care Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5:00 PM on October 28, 2016.

Dependent Care Assistance Program (DCAP)

The DCAP provides an opportunity for employees to authorize a salary reduction on a pre-tax basis to pay for eligible dependent care expenses. For Plan Year 2017, the maximum DCAP salary reduction amount is $5,000 per year ($2,500 if married, filing separately), and, is not subject to Federal or State Withholding or FICA taxes.

Under DCAP, the definition of qualifying person includes:

- A dependent child who is 12 years old or younger, for whom the employee is entitled to a deduction under Internal Revenue Code (IRC) Section 151(c);
- A dependent or spouse of an employee, regardless of age (including elder care), who is mentally or physically incapable of self-care; or

- A child of a divorced or separated employee who is 12 years old or younger, if the employee has custody of the child, even if the employee has released an exemption under IRC Section 152(e)(2).

Eligible expenses include charges for care of a qualifying person inside or outside your home. This includes feeding, administration of medicine, general supervision and nursery school. The main purpose must be the person's well-being and protection.

Expenses for care do not include amounts you pay for food, clothing and entertainment. However, if these amounts cannot be separated from the cost of caring for the qualifying person(s), you can include the total cost.

Federal tax laws specify that to qualify as an eligible expense:

- Out-of-home care must comply with all federal requirements if the facility provides care for more than six non-resident individuals. (State and some local laws require licensing where care is provided to fewer persons.) Out-of-home care for a qualifying person age 13 or older will qualify, provided that person is physically or mentally incapable of self-care and regularly spends at least eight hours each day in your household.
- Children's schooling may be included if your child is not in kindergarten or a higher grade.
- Registration fees for day care are included

You can include only the cost of care in determining your eligible expense. The services must occur during the calendar year for which you are enrolled and on days you work. If you are married, they must also occur on days your spouse works (or if spouse is a full-time student, on days you work and your spouse attends school).

Eligible expenses for this Open Enrollment period begin January 1, 2017. If you become eligible to enroll at a later date, eligible expenses will begin on the first day of the month after your enrollment form has been received and approved by the Employee Benefits Services Unit.

Expenses that are not eligible include:

- The cost of schooling for a child in kindergarten or above;
- Summer camp expenses when the child stays overnight;
- Payments to a person for whom you can claim a dependency exemption for federal income tax purposes;
- Payments to your non-dependent child (for eligible dependent care services) unless he or she will be age 19 or older by December 31, 2017;
- Expenses incurred before January 1, 2017 (or other effective date of enrollment);
- Food, clothing, diapers and entertainment separated from the cost of caring for a qualified person; and,
- Membership fees.

You must carefully estimate the amount of eligible child care and/or dependent care expenses you expect to incur during 2017. Be sure to consider the possibility of declining expenses as your child gets older. Your salary reduction amount is fixed annually during this open enrollment period. The salary reduction you decide on should not exceed your estimate of dependent care expenses as federal tax regulations require forfeiture of any amount not used for expenses incurred within the calendar year.

To enroll in the DCAP, please complete the Dependent Care Assistance Program Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5:00 PM on October 28, 2016.

Enrollment Options

FOR PERMANENT FULL-TIME EMPLOYEES OR PART TIME EMPLOYEE WORKING AT LEAST 20 HOURS PER WEEK IF YOU ARE A MEMBER OF:	CCHP A+B KAISER A HN HMO A HN PPO A	KAISER B HN HMO B HN PPO B HDHP	DENTAL PLANS	PCP	HCSA	DCAP
AFSCME LOCAL 2700 - UNITED CLERICAL, TECHNICAL & SPECIALIZED EMPLOYEES	●	●	●	●	●	●
AFSCME LOCAL 512 - PROFESSIONAL & TECHNICAL EMPLOYEES	●	●	●	●	●	●
SEIU, LOCAL 1021 - SOCIAL SERVICES UNION	●	●	●	●	●	●
PUBLIC EMPLOYEES UNION, LOCAL 1	●		●	●	●	●
CALIFORNIA NURSES ASSOCIATION - WORKING AT LEAST 16 HRS/WK.	●		●	●	●	●
PHYSICIANS' & DENTISTS' ORGANIZATION OF CONTRA COSTA COUNTY	●	●	●	●	●	●
WESTERN COUNCIL OF ENGINEERS	●	●	●	●	●	●
UNREPRESENTED EMPLOYEES	●	●	●	●	●	●
UNREPRESENTED MANAGEMENT EMPLOYEES	●	●	●	●	●	●
DEPUTY SHERIFFS' ASSOCIATION			●	●	●	●
DISTRICT ATTORNEY INVESTIGATORS' ASSOCIATION			●	●	●	●
IAFF LOCAL 1230			●	●	●	●
UNITED CHIEF OFFICERS ASSOCIATION			●	●	●	●
UNREPRESENTED UNIFORMED FIRE MANAGEMENT			●	●	●	●
UNREPRESENTED EXEC. SHERIFF MANAGEMENT			●	●	●	●
PUBLIC DEFENDERS ATTORNEY AND INVESTIGATORS	●	●	●	●	●	●
DEPUTY DISTRICT ATTORNEYS ASSOCIATION	●	●	●	●	●	●
PROBATION PEACE OFFICERS ASSOCIATION	●	●	●	●	●	●
IPTFE LOCAL 21	●	●	●	●	●	●
TEAMSTERS 856***	●	●	●	●	●	●
PERMANENT INTERMITTENT EMPLOYEES(PIE), PROVISIONAL EMPLOYEES, PERMANENT PART-TIME EMPLOYEES WORKING LESS THAN 20 HOURS PER WEEK AND SPECIAL DISTRICT EMPLOYEES *	●	●	●	●		
COBRA PARTICIPANTS **	●	●	●		●	

* Permanent Intermittent Employees are eligible for these plan if noted above for Permanent F/T or P/T employees

** COBRA Participants are eligible for these benefits if noted above for Permanent F/T or P/T employees

*** Also eligible for the Teamsters 856 Trust Fund KP Health Plan

Computer Vision Care (CVC) Program Information

Who is eligible?

The Management Resolution or your Memorandum of understanding (MOU) will advise if you are eligible for this benefit. If this benefit is included in your MOU, the benefit covers:

- Permanent full-time and part-time employees whose job requires use of a computer terminal for at least two (2) hours a day or more, as certified by their supervisor.

What are the benefits?

The benefits of the CVC plan include the following every 12 months:

- An annual CVC vision exam
- Single, bifocal or trifocal lenses
- Frames that are covered under the plan frame allowance
- Up to two total hours of County time to have your exam and to obtain your glasses

Who is the carrier?

Your benefits are provided through Vision Service Plan (VSP).

How do I make arrangement for the CVC exam Approval?

1. Approval forms & Instructions are available on the Benefits Website @ www.cccounty.us
2. **Caution**: Do not make an appointment for vision services until you receive an authorization letter from VSP. **Any services obtained before receiving your VSP authorization may result in you being fiscally liable for those services rendered by your provider. The CVC approval letter is valid only for 60 days.**

Upgrades

You may select frames or materials above the plan allowance, however, you will be responsible for paying the difference in the cost between the plan allowance and your upgrade.

For example, if you select any of the following, there will be an extra charge:

1. Blended lenses.
2. Oversize lenses.
3. Progressive multi focal lenses.
4. Edge treatments and anti-reflective coatings.
5. Solid and gradient plastic dyes.
6. A frame that costs more than the plan allowance.
7. Cosmetic lenses.
8. Optional cosmetic processes.
9. UV (ultraviolet) protected lenses.
10. Tinted lenses other than pink #1 or #2.

Limitations and Exclusions

Not Covered – There is no benefit for professional services or materials connected with:

1. Subnormal vision aids.
2. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer; Plano lenses; or two pair of glasses in lieu of bifocals.
3. Contact lenses.
4. Photochromic or tints greater than 20%
5. Laminated lenses
6. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
7. Medical or surgical treatment of eyes.
8. Services provided by a non-member doctor.
9. Any eye examination or any corrective eye wear required by an employer as a condition of employment.

This is only a partial list of exclusions and limitations to the Vision Service Plan CVC benefit. If you have questions regarding items not listed above, please call Vision Service Plan at 800-877-7195.

Contact List

	Phone Number	Web Site
Health Net HMO	1-800-522-0088	www.healthnet.com
Health Net PPO	1-800-676-6976	www.healthnet.com
CCHP Plans A & B	1-877-661-6230	www.contracostahealthplan.org
Kaiser	1-800-464-4000	www.kp.org
Delta Dental (PPO)	1-800-765-6003	www.deltadentalins.com
DeltaCare USA (HMO)	1-800-422-4234	www.deltadentalins.com
MassMutual	1-800-743-5274	www.retiresmart.com
VSP	1-800-877-7195	www.vsp.com
EAP - DSA & IAFF & UCOA	1-800-227-1060	
EAP for all others	1-925-930-3661	www.cccounty.us
CalPERS Long Term Care		
- General	1-800-266-1050	www.calpers.ca.gov
- Enrolled member	1-800-982-1775	www.calpers.ca.gov
Health Insurance Marketplace		www.coveredca.com www.healthcare.gov www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions

Open Enrollment Procedures

Before completing enrollment forms, consider the following:

1) Review your personalized 2016 Benefit Statement.
   a) The statement reflects the plans in which you currently participate; and,
   b) Family members currently enrolled in your health care and dental plans; and,
   c) 2016 elections for Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP).
2) Confirm that all dependents listed satisfy and will continue to satisfy the definition of "eligible dependent" as defined earlier in this Guide.
3) Review the 2017 Employee Benefits Information and Open Enrollment Guide, and, the 2017 SBC.
4) Decide whether or not you are going to continue the same health care and dental care plan as listed on your Benefits Statement.
   a) If you are not making a plan change nor are you adding or deleting a dependent, you do not need to complete the 2017 Benefits Open Enrollment Medical & Dental Change Form that was enclosed with your benefit statement.
   b) If you are changing a health care plan or dental care plan or are adding or deleting family members, then you will need to complete the 2017 Benefits Open Enrollment Medical & Dental Change Form and return the form to the Employee Benefits Services Unit on or before 5:00 PM on October 28, 2016.
5) Complete the Health Care Spending Account Expense Worksheet to determine if you should consider participating in the HCSA. To enroll in the HCSA, please complete the 2017 Flexible Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5:00 PM on October 28, 2016. This worksheet and enrollment form are available on the Employee Benefits website.
6) Complete the Dependent Care Assistance Program Worksheet to determine if you should consider participating in the DCAP. To enroll in the DCAP, complete the Flexible Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5:00 PM on October 28, 2016. This worksheet and enrollment form are available on the Employee Benefits website.
7) The 2017 monthly medical and dental premium rate sheet was included in the mailing you received. This information is also available on the Employee Benefits website.

The Supplemental Life Insurance

1) Supplemental Life Insurance amounts for you or family members may be increased or decreased in accordance with the Plan provisions by requesting, completing and submitting the required application forms to VOYA Benefits. Forms and directions are available on the County website at http://www.cccounty.us.
2) It's a good time to update your life insurance beneficiary information. Remember, you may designate beneficiaries for your Basic Life Insurance, Supplemental Life Insurance and Management Life Insurance. Please read the instructions, complete the form and return it to the Employee Benefits Services Unit.
3) Designation of Beneficiary Form can be located on the County website at http://www.cccounty.us under Employee Benefits Open Enrollment.

The Following Options Are Not Included In The Open Enrollment Process, But Should Be Reviewed Annually.

If you were hired as a permanent full-time or permanent part-time employee on or after January 1, 2009 or the date as stated in your Memorandum of Understanding (MOU), please review our website regarding Deferred Compensation. You may be eligible for the Deferred Compensation Special Benefit (you defer $25.00 and the County contributes $150.00)

1) It is also a good time to review your Deferred Compensation Account. To review your account with our MassMutual Representative or to change your deferral amount, investment allocation or beneficiary for the Contra Costa County Deferred Compensation Plan, please contact MassMutual at 1-866-617-7901.

MEDICARE ELIGIBLE AND STILL WORKING

If you are an active employee approaching age 65 or have attained the age of 65, the following information is to help you understand Medicare and how it coordinates with the health care benefits provided by Contra Costa County.

Medicare Part A Insurance – Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (Not custodial or long-term care). It also helps cover hospice care and some home health care. Medicare beneficiaries must meet certain conditions to get these benefits.

Medicare Part B Insurance – Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

It is not necessary for you or your spouse to enroll in Medicare Part B while you are an active employee and include your spouse on your medical plan with Contra Costa County. You may postpone your enrollment in Medicare Part B, without penalty, until the time you retire.

Once you retire, you and your Medicare eligible spouse must enroll in Medicare Part B in a very timely manner. Failure to enroll in the prescribed time will subject you to a penalty of 10% per year for each year you delay enrollment. This penalty continues the entire time you are enrolled in Medicare.

At the time of your retirement, contact Social Security who will provide you with a form for the County to complete to verify your group medical coverage through the County. Bring this form to the Employee Benefits Services Unit.

Medicare Part D or Prescription Drug Coverage – Most people will pay a monthly premium for this coverage. Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Medicare Beneficiaries get to choose the drug plan and pay a monthly premium. Like other insurance, if a Medicare beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

It is not necessary for you or your spouse to enroll in Medicare Part D Prescription Drug Coverage while you are an active employee and include your spouse on your medical plan with Contra Costa County. Additionally, at the present time, it is not necessary for you and your spouse to enroll in Medicare Part D Prescription Drug Coverage once you are retired and continue to participate in the retiree medical plans. See the section entitled Notice of Creditable Coverage for additional information.

2017 Health Plan Comparison Guide

2017 Contra Costa County Health Plan Comparison Guide

HMO PLANS

	Kaiser Permanente				Health Net HMOs	
	Kaiser HMO Plan A	Kaiser HMO Plan B	HDHP	Teamsters 856 Trust Fund KP	Health Net HMO Plan A	Health Net HMO Plan B
Network Eligibility	You must live or work in a Kaiser service area at the time of enrollment.	You must live or work in a Kaiser service area at the time of enrollment.	You must live or work in a Kaiser service area at the time of enrollment.	You must live or work in a Kaiser service area at the time of enrollment.	You must reside in a Health Net service area.	You must reside in a Health Net service area.
Calendar Year Deductible						
Individual	None	$500	$1,500	None	None	None
Family	None	$500**/ $1,000 Member/Family**	$2,600**/ $3,000 Member/Family**	None	None	None
When does the Deductible apply?	N/A	Deductible applies to all hospital related services as noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % or copay	N/A	N/A	N/A
Max Calendar Year Out of Pocket (OOP) Expense						
Individual	$1,500	$3,000	$3,000	$1,500	$1,500	$2,000
Family	$1,500**/$3,000 Member/Family**	$3,000**/ $6,000 Member/Family**	$3,000**/ $6,000 Member/Family**	$3,000	$4,500	$6,000
What counts towards the OOP Max? The Out of Pocket (OOP) Maximum is the most you would have to pay during a plan/calendar year for health care services. If you reach the Out of Pocket Maximum, your plan will pay 100% of covered service costs for the remainder of the year.	All Copays/Coinsurance apply to OOP except those for: Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP
Hospital Services						
Inpatient	$0	10% after deductible	10% after deductible	$0	$0	$1,000
Outpatient Surgery (at a Facility)	$10	10% after deductible	10% after deductible	$15 per procedure	$0	$500
Emergency Services						
Emergency Department Visits	$10	10% after deductible	10% after deductible	$35 per visit (Waived if admitted)	$25	$100
Ambulance	$0	$150	10% after deductible	$0	$0	$0

* For the purpose of Deductible and Out of Pocket Maximum limits "Family" means any coverage level other than Individual including Employee + 1 and Employee + 2 or more

		PPO PLANS			
Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
CCHP Plan A	CCHP Plan B	Health Net PPO Plan A		Health Net PPO Plan B	
		In Network	Out of Network	In Network	Out of Network
You must reside in or work for or have worked for Contra Costa County.	You must reside in or work for or have worked for Contra Costa County.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.
None	None	$250	$250	$500	$500
None	None	$750	$750	$1,500	$1,500
N/A	N/A	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.
N/A	$1,500	$1,500	$5,000	$3,000	$9,000
N/A	$3,000	$3,000	$10,000	$6,000	$18,000
N/A	All Copays apply to OOP except those for: Chiropractic, Acupuncture	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required
$0	$0	10%	30%	20%	40%
$0	$0	10%	30%	20%	40%
$0	$0	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
$0	$0	10%	10%	20%	40%

2017 Contra Costa County Health Plan Comparison Guide (Continued)

HMO PLANS

	Kaiser Permanente				Health Net HMOs	
	Kaiser HMO Plan A	Kaiser HMO Plan B	HDHP	Teamsters 856 Trust Fund KP	Health Net HMO Plan A	Health Net HMO Plan B
Physician Services						
Office Visits	$10	$20	10% after deductible	$15	$10	$20
Preventive Exams	$0	$0	$0	$0	$0	$0
Urgent Care Visits	$10	$20	10% after deductible	$15	$15	$50
Allergy Injections	$3	$0	10% after deductible	$0	$0	$0
Physical, Occupational, Speech Therapy	$10	$20	10% after deductible	$15	$10	$0
Diagnostic X-Ray & Lab	$0	$10	10% after deductible	$0	$0	$0
Prescription Drugs						
Retail Pharmacy - 30 (Kaiser or Health Net) or 90 (CCHP) day supply	$10 generic $20 brand	$10 generic $30 brand	$10 generic $30 brand after deductible	$10 generic (up to 100 day supply) $20 brand (up to 100 day supply)	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary
Mail-Order Pharmacy - 100 (Kaiser) or 90 (Health Net or CCHP) day supply	$10 generic $20 brand	$20 generic $60 brand	$20 generic $60 brand after deductible	$10 generic $20 brand	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary
Additional Services						
Durable Medical Equipment	$0	20% (no deductible)	10% after deductible	$0	$0	$0
Vision (Routine exam only, materials not covered except as noted)	$0	$0	10% after deductible	$0	$10	$20
Hearing Exams	$0	$0	$0	$0	$10	$20
Infertility - diagnosis and treatment only	$10	50% (no deductible)	Not Covered	Subject to applicable copays	50%	50%
Home Health Services	$0 up to 100 visits	$0 up to 100 visits	$0 up to 100 visits	$0	$0	$20 starting w/ 31st day
Skilled Nursing Care	$0 up to 100 days	10% (no deductible) up to 100 days	10% after deductible, 100 days	$0	$0 up to 100 days	$1,000 up to 100 days
Hospice	$0	$0	$0	$0	$0	$0
Acupuncture	Not Covered	Not Covered	Not Covered	$15	Discounts available	Discounts available
Chiropractic	$15 up to 20 visits	$15 up to 20 visits	Not Covered	$15	$10 up to 20 visits	$10 up to 20 visits

Notes:

		PPO PLANS			
Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
CCHP Plan A	CCHP Plan B	Health Net PPO Plan A		Health Net PPO Plan B	
		In Network	Out of Network	In Network	Out of Network
$0	$5	$10	30%	$20	40%
$0	$0	$0	Not Covered	$0	Not Covered
$0	$5	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
$0	$0	10%	30%	$20	40%
$0	$5	10%	30%	20%; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
$0	$0	10%	30%	20%	40%
$0	$3 up to 90 day supply	$5	$5	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary
Covered	$3 up to 90 day supply	$10	$10	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary
$0	$0	50%	50%	20%	40%
$0; up to $65 allowance for glasses or contacts	$5; up to $65 allowance for glasses or contacts	$10 through age 16	Not Covered	$20 through age 16	Not Covered
$0	$5	$10 through age 16	Not Covered	$20 through age 16	Not Covered
$0 Infertility – diagnosis and artificial insemination only	$5 Infertility – diagnosis and artificial insemination only	50% after $500 Infertility deductible; (maximum benefit of $2500 per calendar year and lifetime maximum benefit of $10,000)	50% after $500 Infertility deductible; (maximum benefit of $2500 per calendar year and lifetime maximum benefit of $10,000)	20%; after $500 Infertility deductible; up to a combined $2,000/lifetime max	40%; after $500 Infertility deductible; up to a combined $2,000/lifetime max
$0	$0	20%; up to 100 visits combined PPO/OON	20%; up to 100 visits combined PPO/OON	20%; up to 100 visits combined PPO/OON	40%; up to 100 visits combined PPO/OON
$0 up to 100 days per benefit period	$0 up to 100 days per benefit period	20%; up to 100 days combined PPO/OON	20%; up to 100 days combined PPO/OON	20%	40%
$0	$0	20%	20%	20%	40%
$0 up to 10 visits	$5 up to 10 visits	20%	20%	$20; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
$0 up to 10 visits	$5 up to 20 visits	Not covered; Discounts available	Not covered; Discounts available	$20; limited to 20 visits (in and out of network combined) $25 max payable per visit	40%; limited to 20 visits (in and out of network combined) $25 max payable per visit

*Copayments are waived for services at CCRMC

*The PPO benefits available to non-California residents slightly differ from the above. For non-California PPO plan design details, please refer to the Evidence of Coverage (EOC).

2017 Dental Plan Comparison Guide

PLAN NAME	DELTA DENTAL	
ELIGIBILITY	You may receive services from any licensed dentist. The amount paid is determined on whether the dentist is a participating or a non-participating dentist.	
HOW TO FIND OR CONFIRM IF A DENTIST IS A MEMBER	800-765-6003	
SPECIALTY REFERRALS	Free choice by member	
DEDUCTIBLE	One time $50 per family	
MEMBER SERVICES	Participating Dentist PLAN PAYS:	
DIAGNOSTICS:		
ORAL EXAMINATION AND DIAGNOSIS	70%	
OFFICE VISITS	70%	
FULL MOUTH X-RAYS:	70%	
SINGLE FILM	70%	
EACH ADDITIONAL FILM	70%	
TEETH CLEANING (PROPHYLAXIS-TREATMENT TO INCLUDE SCALING AND POLISHING)	70% (1)	
SEALANTS PER TOOTH (3)	70%	
ORAL HYGIENE INSTRUCTION	Not Covered	
TOPICAL FLUORIDE	70%	
SPACE MAINTAINERS	70%	
SPECIALIST CONSULTATION	70%	
BIOPSY OF ORAL TISSUE (SOFT)	70%	
EMERGENCY TREATMENT	70%	
EMERGENCY TREATMENT (AFTER NORMAL WORKING HOURS)	70%	
BROKEN APPOINTMENT CHARGE (LESS THAN 24 HOUR NOTICE)	Determined by Dentist	
PERIODONTICS:		
SUBGINGIVAL CURETTAGE - PER QUADRANT	70%	
GINGIVECTOMY - PER QUADRANT	70%	
OSSEOUS SURGERY - PER QUADRANT	70%	
ENDODONTICS:		
PULP CAPPING	70%	
PULPOTOMY	70%	
ROOT CANAL THERAPY - PER CANAL:		
EXCLUDING SECOND OR THIRD MOLARS	70%	
SECOND OR THIRD MOLARS	70%	
APICOECTOMY AND FILLING CANAL	70%	
APICOECTOMY ON SEPARATE APPOINTMENT	70%	
RESTORATIVE:		
PIN BUILD UP UNDER FILLING	70%	
ALL FILLINGS OF PERMANENT AND PRIMARY TEETH	70%	

(1) Teeth Cleaning is limited to twice per calendar year. One additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant if pregnant.
(2) Teeth Cleaning is limited to one procedure each six month period
(3) Sealants limited on first molars up to age 9 and second molars up to age 16

	DELTACARE USA- PLAN CA A16 (HMO)
	You must visit a dentist from the current list of DeltaCare USA network dentists. If a dentist who is NOT on the list provides treatment, it will not be covered by your DeltaCare USA program. DeltaCare USA is offered and administered by Delta Dental Insurance Company.
	Refer to the DeltaCare USA Evidence of Coverage (EOC) or contact DeltaCare at 800-422-4234
	Specialist Services must be referred by an assigned DeltaCare USA dentist.
	None
Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70% (1)	No Cost (2)
Up to 70%	No Cost
Not Covered	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Determined by Dentist	$10 per 15 minutes of appointment time
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost

2017 Dental Plan Comparison Guide (Continued)

PLAN NAME	DELTA DENTAL (PPO)
MEMBER SERVICES	Participating Dentist PLAN PAYS:
CROWNS AND BRIDGES: (4):	
CROWNS - PER UNIT	70%
BRIDGES - PER UNIT	50%
STAINLESS STEEL CROWNS	70%
DOWEL PIN (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%
PIN BUILD UP	70%
POST AND CORE (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%
RECEMENTATION:	
INLAY	70%
CROWN	70%
BRIDGE	70%
PROSTHETICS: (5)	
DENTURES:	
COMPLETE UPPER OR LOWER DENTURE - PER DENTURE	50%
PARTIAL UPPER OR LOWER DENTURE - PER DENTURE	50%
STAYPLATE	50%
DENTURE ADJUSTMENTS	50%
DENTURE RELINE	50%
DENTURE AND PARTIAL REPAIRS	50%
DENTURE DUPLICATION (REBASE)	50%
ADDING TEETH OR CLASPS TO PARTIAL DENTURE - PER UNIT	50%
IMPLANTS	50%
ORAL SURGERY:	
EXTRACTIONS; LOCAL ANESTHESIA (SIMPLE)	70%
SURGICAL EXTRACTION	70%
IMPACTIONS:	
SOFT TISSUE	70%
PARTIAL BONY	70%
FULL BONY	70%
FRENECTOMY	70%
ALVEOLECTOMY - PER QUADRANT	70%
GENERAL ANESTHESIA WITH ORAL SURGERY	70%
ORTHODONTIA:	
FULL BANDED CASE	Not Covered
ORTHODONTIA: For Deputy Sheriff's Assoc. (DSA) and District Attorney Investigators Assoc. (DAIA)	
FULL BANDED CASE	50%/ Up to 50%
MAXIMUM BENEFIT PAYMENTS PER CALENDAR YEAR Bargaining Unit DSA, DAIA, IAFF, UCOA & PDOC Unrepresented and All Other Bargaining Units	 $1,600.00 Per Member $1,800.00 for certain bargaining units (refer to MOU)

(4) Gold, if used, will be an additional charge to the member.
(5) Benefits are subject to a maximum allowance and there is a six month waiting period on these services for new enrollees.

	DELTACARE - PLAN CA A16
Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
Up to 70%	No Cost
Up to 50%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 50%	No Cost
Up to 50%	No Cost
Up to 50%	No Cost
Up to 50%	No Cost
Up to 50%	
Up to 50%	No Cost
Up to 50%	No Cost
Up to 50%	No Cost
Up to 50%	Not Covered
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	No Cost
Up to 70%	Not Covered
Not Covered	$350.00 Start up fee
	$1,250/children
	$1,450/adults
$ 2,000 lifetime maximum per person	
	NO MAXIMUM

LEGISLATION

LEGISLATION

MICHELLE'S LAW

Michelle's Law requires group health plans to continue dependent health coverage during a dependent's medically necessary leave of absence from post-secondary education if that dependent would have otherwise lost coverage due to lack of student status.

You are required to notify Contra Costa County 30 days before the leave begins if the leave dates are known in advance, or, within 30 days after the start date of the unplanned medical leave of absence. You will need to provide a signed note from your dependent's physician that includes the following notification details:

1. the medical necessity
2. ICD code (diagnosis code)
3. leave start date
4. expected end date
5. physician's name and address
6. physician's signature and date signed

MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) EXTENSION ACT (MMSEA)

The MMSEA imposes a new reporting requirement on group health plans that cover Medicare-eligible individuals. The legislation requires the reporting of Social Security Numbers (SSNs) for affected members.

SSNs are required for all dependents enrolled in a group health plan with Contra Costa County. Employees/Retirees/Survivors without this information on file will be contacted to update the required records.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Mental Health Parity is designed to remove any day or dollar limitations to treatment for mental health and substance abuse conditions. Some highlights of this law are:

- Applies to group health plans
- Includes both mental health and substance abuse benefits
- If the plan covers mental health and substance abuse disorders, employers are required to cover mental illness and addiction treatment under the same conditions and terms as for other medical conditions.

The Health Plan Comparison Guides have been updated to reflect the required changes.

In addition, Contra Costa County provides an Employee Assistance Program that can help employees and their families with securing appropriate treatment for mental health and substance abuse conditions.

Contra
Costa
County

Human Resources
Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and de pendent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or if the Plan provides retiree health coverage: commencement of a proceeding in a bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.

Human Resources Department
Employee Benefits Service Unit
651 Pine Street, 5th Floor, Martinez, CA 94553
Phone Number 925-335-1746

Other coverage options besides COBRA Continuation Coverage.

Instead of enrolling in COBRA continuation coverage, there may be more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, If you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options,because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Duration of COBRA Coverage

18-month period Generally, when there has been a termination of employment or a reduction in hours that causes coverage to be lost, COBRA coverage for a Qualified Beneficiary begins the day after County-provided health plan coverage is lost, or begins as of the first day of the next month, and continues for up to 18 months.

36-month period. COBRA coverage for your covered spouse or dependent child is 36 months from the date plan coverage is lost due to any of the following events: medicare eligibility of the employee; former employee dies; the employee and spouse are divorced or legally separated; or, for the dependent child only, the dependent child loses status as a dependent under the County's health plan. You, your spouse, or any dependent(s) must notify us, the Employee Benefits Services Unit, within 60 days in writing in case of divorce or the dependent child ceasing to be eligible.

29-month period for disabled qualified beneficiaries. If a Qualified Beneficiary (including you) is disabled, COBRA coverage for all Qualified Beneficiaries continues for up to 29 months from the date COBRA coverage would begin. A 29 month period applies under federal COBRA only if the following conditions are satisfied: (1) the Social Security Administration determines the Qualified Beneficiary is disabled at the time of the qualifying event or within 60 days of when COBRA coverage begins; and (2) the Qualified Beneficiary provides the County a copy of the determination within the initial 18 month coverage period and not later than 60 days after the determination is made. The premium for COBRA coverage increases after the 18th month of coverage to 150% of the applicable premium for the disabled Qualified Beneficiary, as well as other Qualified Beneficiaries, if they are in the same rate band.

Early Termination of COBRA Coverage

COBRA coverage can terminate before the period described above expires. COBRA coverage for a Qualified Beneficiary terminates on the earliest of: the month for which the premium for the Qualified Beneficiary's COBRA coverage is not timely paid; the date the County ceases to maintain any group health plan; after electing COBRA coverage, the date the Qualified Beneficiary becomes (a) entitled to Medicare or (b) covered by another group health plan that contains no exclusion or limitation for pre-existing conditions of the Qualified Beneficiary, or which exclusion or limitation does not apply due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a Qualified Beneficiary is entitled to 29 months of COBRA coverage on account of disability, but is later determined not to be disabled, coverage ends with the first month beginning more than 30 days after that determination. For further information, please contact the Contra Costa County plan administrator:

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified or the second qualifying event within 60 days of the second qualifying event.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Employee Benefits Service Unit at 925-335-1746 or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Contra Costa County

Human Resources Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

DATE: For Plan Year January 1, 2017 – December 31, 2017

NOTICE TO: Participants in Contra Costa County Employee/Retiree Health Plans (non CalPERS)

FROM: Ann Elliott, Employee Benefits Manager

Important Notice from Contra Costa County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Contra Costa County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Contra Costa County has determined that the prescription drug coverage offered by the Contra Costa County Employee/Retiree health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

NOTICE OF CREDITABLE COVERAGE FOR PLAN YEAR JANUARY 1, 2017 – DECEMBER 31, 2017

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Contra Costa County coverage will be terminated.

If you do decide to join a Medicare drug plan and drop your current Contra Costa County coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Contra Costa County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Call Employee Benefits Service Unit at (925) 335-1746.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Contra Costa County changes. You also may request a copy of this notice at any time.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

IRS REGULATIONS - DOMESTIC PARTNER BENEFITS

Contra Costa County complies with Internal Revenue Service regulation revisions and official guidance that affects imputation of income to certain employees in regard to health benefits. The County imputes income for state and federal income tax purposes for employees who receive County paid health benefits for domestic partners. This results in imputation of less income, and lowered FICA payments, for certain affected employees and in imputation of larger amounts of income, and increased FICA payments, for other affected employees.

Employees that have Domestic Partner coverage only will have income imputed based on the County's subsidy for the single rate.

Example: If the County's subsidy for single coverage for the plan is $509.92 the income imputed to the employee will be equal to the County's subsidy for the single rate, or $509.92.
Employees that have family coverage that includes either a Domestic Partner or a Domestic Partner and the Domestic Partner's child(ren) will have imputed income based on the value of the benefit received for the Domestic Partner and his or her child(ren).

Example: If the County's subsidy for family coverage for the plan is $1,214.90 per month and an employee has family coverage for his or her child plus a Domestic Partner, income will be imputed to the employee equal to the County subsidy for the single rate, or $509.92 per month, for the Domestic Partner's coverage. If an employee has family coverage for a Domestic Partner and a domestic partner's child then the imputed income would be equal to the County's subsidy for two single rates or $1,019.81 per month. If an employee has family coverage for a Domestic partner and two or more of the domestic partner's children, the imputed income would be the full County subsidy for the family rate, or $1,214.90 per month.

If you have any questions regarding the imputation of income or other tax issues, please consult your tax advisor. If you have any questions regarding your domestic partner premium deductions, please contact the Human Resources Department Employee Benefits Services Unit at 925-335-1746.

IRS CODE 152

In limited circumstances, your domestic partner and the dependent children of your domestic partner may qualify as a "federal tax dependent" under Internal Revenue Code (IRC) Section 152 (as modified by section 105(b)) for health coverage purposes, provided certain qualifying conditions are met. Employer-provided health insurance coverage for a federal tax dependent is not subject to federal income tax and will not be included in your gross income. Additionally, such coverage can be provided on a pre-tax basis and eligible medical expense claims for that dependent can be reimbursed on a pre-tax basis through a health care flexible spending account.

To qualify as a federal tax dependent during a given tax year, a person must meet all of the following qualifications:

1. Is a dependent who shares your principal residence for the full tax year (January 1 through December 31), except for temporary absences such as vacation, military service or education; and
2. Is a dependent who receives more than half of their support from you; and,
3. is a dependent who is a citizen or resident of the United States or a country contiguous to the United States.

The rules are complicated and this provides only a brief summary of the requirements for qualifying as a federal tax dependent. You are encouraged to consult with an individual tax advisor to determine whether your domestic partner and/or children of your domestic partner satisfy these requirements.

You must complete a Declaration of Tax Dependent Status form each calendar year. You can find the form at www.cccounty.us.

Contra Costa County

Human Resources Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

DATE: For Plan Year January 1, 2017 - December 31, 2017

NOTICE TO: Participants in Contra Costa County Employee/Retiree Health Plans

FROM: Ann Elliott, Employee Benefits Manager

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**LOUISIANA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
ALASKA – Medicaid	**MAINE** – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741
ARIZONA – Chip	**MASSACHUSETTS** – Medicaid and CHIP
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
COLORADO – Medicaid	**MINNESOTA** – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629
FLORIDA – Medicaid	**MISSOURI** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
IDAHO – Medicaid	**NEBRASKA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
INDIANA – Medicaid	**NEVADA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Medicaid Website: http://dwss.nv.gov/Medicaid Phone: 1-800-992-0900
IOWA – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KANSAS – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
KENTUCKY – Medicaid	**NEW YORK** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	**TEXAS** – Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH DAKOTA– Medicaid	**UTAH** – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OKLAHOMA – Medicaid and CHIP	**VERMONT** – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Medicaid Website: http://www.dmas.virginia.gov/ rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ inde x.aspx Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA – Medicaid	**WYOMING** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

The benefit plan information and comparison charts in this Open Enrollment Guide are meant only as a summary of benefits. This information does not fully describe your benefit coverage. For details on benefit coverage, please refer to the Evidence of Coverage documents provided by Contra Costa Health Plan, Health Net, Kaiser Permanente and Delta Dental.

For additional information on the benefit and claims review process and adjudication procedures, please refer to the Evidence of Coverage documents.

If there are any discrepancies between the information included in this 2017 Open Enrollment Guide and the 2017 Evidence of Coverage from the carriers, the Evidence of Coverage will prevail.

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CONTRA COSTA COUNTY